INSTRUCTIONS FOR
NOTIFICATION OF HEALTH INSURANCE COVERAGE

IMPORTANT NOTE: This form must be filed with the Arizona Department of Revenue by the 15th day of the month following the month in which health insurance coverage commences. All applicants for a given month can be list on this form.

HEALTH CARE INSURER COMPANY NAME

Please print the name of the health care insurance company that will be providing health insurance to the applicants listed on the bottom of the form.

HEALTH CARE INSURER ADDRESS NUMBER AND STREET OR PO BOX and CITY, STATE, ZIPCODE

Please print the complete mailing address of the health care insurance company as it would appear on the insurance premium tax return.

CONTACT PERSON NAME AND PHONE NUMBER

Please print the name and phone number of the person that will be signing the application and that may be contacted if the Department of Revenue has questions regarding the information on the Notification of Health Insurance.

NAIC #

Please write the NAIC # as it would appear on your insurance premium tax return.

FEDERAL IDENTIFICATION #

Please write the Federal Identification number of the health care insurance company as it would appear on the Arizona Insurance Premium Tax return.

INSTRUCTIONS FOR THE TABLE ON THE NOTIFICATION OF HEALTH INSURANCE COVERAGE

COLUMN (a): INSURED NAME

Please print the name of each person or small business insured in the month for which this NOTIFICATION is being submitted. The name shown in this column should match that shown on the Certificate of Eligibility.

COLUMN (b): CERTIFICATE NUMBER

Please write the Certificate Number from the Certificate of Eligibility for each insured person or small business.

COLUMN (c): DATE FOR WHICH INSURANCE COVERAGE WAS APPLIED

Please write the date on which the individual or small business applied for health insurance coverage.

COLUMN (d): DATE INSURANCE COVERAGE WAS OBTAINED

Please write the date on which insurance coverage was approved for the applicant. This may or may not be the same date on which insurance coverage commenced.

COLUMN (e): DATE INSURANCE COVERAGE COMMENCED

Please write the date on which health insurance coverage commenced for the individual or small business. Each NOTIFICATION submitted should only list applicants for which insurance coverage commenced in the same month.

COLUMN (f): COVERAGE RECEIVED

This column should reflect the coverage that the applicant received.

For an individual, the coverage would be (1) "applicant" indicating that only the applicant is receiving health insurance coverage, (2) "X dependent(s)", X being the number of dependents, indicates that coverage is for the applicant's dependent(s) only or (3) "family" indicating that the entire family is being covered.

For a small business, the coverage would be "X single, X family", X being the count. For example, the small business may be getting coverage for 3 single and 5 family.

COLUMN (g): STATUTORY CREDIT ALLOWANCE

This column is a calculation that equals the coverage indicated in Column (f) times the statutory allowances. The statutory allowances are as follows.

For an individual:

"Applicant" is equal to a credit allowance of $1000.

"X dependents" is equal to a credit of $500 for each dependent.

"Family" is equal to a credit of $3000.

For a small business:

"X single" (where X is a number) is equal to a credit allowance of $1000 for each employee electing single coverage.

"X family" (where X is a number) is equal to a credit allowance of $3000 for each employee electing family coverage.

The statutory credit allowance cannot <u>exceed</u> the amount shown on the Certificate of Eligibility.

COLUMN (h): 50% OF ANNUAL HEALTH INSURANCE PREMIUM

Please write the dollar amount that is equal to 50% of the individual's or small business' annual health insurance premium.

COLUMN (i): ALLOWABLE CREDIT

Please write the allowable insurance premium tax credit for this particular individual or small business. This should be the lesser of column (e) or column (f).

This Notification must be signed by the health care insurance company contact person and dated. Failure to complete the form in full may affect the amount of insurance premium tax credit which the health insurance company may claim.

Submit the completed form, or a replica of the completed form as produced on your own system, to:

Georganna Meyer, Chief Economist
Office of Economic Research and Analysis
Arizona Department of Revenue
PO Box 25248
Phoenix, AZ 85002

If you have questions, call Georganna at (602) 716-6927.